



## Beth Israel Deaconess HealthCare<sup>SM</sup>

Medical Care of Boston Management, Inc. d/b/a Beth Israel Deaconess HealthCare (BIDHC) understands that you may receive some of your health care from providers other than BIDHC. We also know that it is important for those providers to have up-to-date information about the health care you received at BIDHC so they can provide you with the best care possible. Therefore, for the benefit of our patients, BIDHC participates in health information exchanges (HIEs) to facilitate the secure electronic sharing of your health information with other HIE participants involved in your health care.

Your medical information will be automatically made available by Beth Israel Deaconess HealthCare (BIDHC) through HIEs unless you choose to opt-out. If you choose to opt-out, BIDHC will not share any of your health information through the HIEs and your non-BIDHC health care providers will not be able to access your BIDHC health care information through the HIEs. You may opt-out at any time. To do so, please complete our **HIE Opt-Out Form** and submit it as indicated on the form. If you opt-out and later change your mind you may opt back in at any time. To do so, please complete our **Cancellation of HIE Opt-Out Form** and submit it as indicated on the form. Please understand that if you opt-out of the HIEs that BIDHC participates in, BIDHC will still be able to access your health information in the HIE that another participant has shared. The forms are available at <https://www.bidmc.org/centers-and-departments/bidhc-primary-care/patient-information> or at your practice front desk.

For more information, download Details about patient information in HIE at <https://www.bidmc.org/centers-and-departments/bidhc-primary-care/patient-information> If you have any questions about BIDHC's participation in HIEs or your choices, please contact BIDHC's Privacy Office at [BIDHCCompliance@bidmc.harvard.edu](mailto:BIDHCCompliance@bidmc.harvard.edu)

BIDHC participates the following Health Information Exchanges:

Care quality

Commonwell

MassHiway

New Hampshire Health Information Organization (NHHIO)



Details about patient information in Health Information Exchanges (HIEs):

**1. How Your Information Will Be Used.** Your electronic health information will be used by the Providers and authorized personnel in which Medical Care of Boston Management, Inc. d/b/a Beth Israel Health Care (BIDHC), other providers and organizations involved in your care, authorized personnel of these providers and organizations you approve only to:

- Provide you with medical treatment and related services.
- Check whether you have health insurance and what it covers.
- Evaluate and improve the quality of medical care provided to all patients.
- Perform administrative management of BIDHC

**2. What Types of Information About You Are Included.** If you give consent, the providers may access the information in the following categories below. This includes information created before and after the date of this Consent Form

Patient Demographics	Insurance Information	Advance directives	Problems/diagnoses
Allergies and alerts	Medication lists	Immunizations	Family History
Social History	Vital signs	Medical test results	Procedures
Encounters	Medical Equipment	Plan of care	Health care providers

**3. Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance (“Information Sources”). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other e-health organizations that exchange health information electronically.

**4. Who May Access Information About You.** Only these people may access information about you: BIDHC Providers and providers of BIDHC subsidiaries involved in your medical care; other providers and organizations involved in your care; authorized personnel of these providers and organizations; authorized personnel in the BIDHC network.

**5. Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, please email BIDHC’s Privacy Office at [BIDHCCompliance@bidmc.harvard.edu](mailto:BIDHCCompliance@bidmc.harvard.edu) or call 617-754-0541

**6. Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by a Participating Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.



**HIE Opt-Out Form**

1. I wish to opt-out of the HIEs in which Medical Care of Boston Management, Inc. d/b/a Beth Israel Health Care (BIDHC) participates. I understand that by making this decision my health information will not be shared by BIDHC through these HIEs to any HIE participants outside of BIDHC involved in my care, even in cases of a medical emergency.

2. I understand that this HIE Opt-Out Form only prohibits BIDHC from sharing my health information through the HIEs that BIDHC participates in. I understand that my non-BIDHC health care providers may also participate in HIEs. If I wish to opt-out of HIEs my non-BIDHC providers participate in, I am responsible for contacting each of my non-BIDHC health care providers for information on how to opt-out.

3. I understand that this opt-out will remain in effect unless I choose to opt back in. I may opt back in at any time by completing BIDHC's **Cancellation of Health Information Exchange (HIE) Opt-Out Form** and submitting as indicated on the form.

4. This opt-out does not apply to any of your health information shared by BIDHC through the HIEs before this opt-out takes effect.

I understand that it may take up to ten business days, from date of receipt, for this request to be implemented.

<input checked="" type="checkbox"/> _____		
Patient's Signature		
_____		
Print Name		
Date: ___/___/___ Time: ___:___ o a.m. o p.m.		
<b>OR</b>		
<input checked="" type="checkbox"/> _____		
Signature of Person authorized to sign for patient		
_____	<b>and</b>	_____
Print Name		Relationship to patient
Date: ___/___/___ Time: ___:___ o a.m. o p.m.		

**Please submit completed form at your practice front desk or mail to BIDHC Health Information, 464 Hill side avenue, Suite 304, Needham MA 02494.**



**Cancellation of Health Information Exchange (HIE) Opt-Out Form**

1. I wish to cancel my previous decision to opt-out of the HIEs in which Medical Care of Boston Management, Inc. d/b/a Beth Israel Health Care (BIDHC) participates. I understand that by making this decision I am authorizing my health information to be shared by BIDHC through these HIEs. I understand that the information shared may include information of a more sensitive nature, including but not limited to: genetic diseases or tests, substance use disorder, mental health conditions, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases (STDs), and birth control and abortion (family planning).

2. I understand that if I change my mind, I may at any time later opt back out of the HIEs in which BIDHC participates by completing and submitting a new **Health Information Exchange (HIE) Opt-Out Form** as indicated on the form.

I understand that it may take up to ten business days, from date of receipt, for this request to be implemented.

<input checked="" type="checkbox"/> _____		
Patient's Signature		
_____		
Print Name		
Date: ___/___/___ Time: ___:___ o a.m. o p.m.		
<b>OR</b>		
<input checked="" type="checkbox"/> _____		
Signature of Person authorized to sign for patient		
_____	<b>and</b>	_____
Print Name		Relationship to patient
Date: ___/___/___ Time: ___:___ o a.m. o p.m.		

**Please submit completed form at your practice front desk or mail to BIDHC Health Information, 464 Hill side avenue, Suite 304, Needham MA 02494.**